

ATOL: Art Therapy OnLine, 5 (1) © 2014

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The Search for The Art Therapy Method: One or Many?

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Abstract

Art Therapy may be described as a therapeutic method that employs the use of “images” to facilitate “communication” in the therapeutic setting (Case & Dalley 1992). We may visualize an art therapy grid, where the image making process (the vertical axis) is facilitated in different ways, and the communication (the horizontal axis) moves along a continuum, from intra-psychic to interpersonal. This *articulation* makes the art therapy method very flexible, suitable to respond to different needs of the clients, through different interventions. In this presentation I illustrate three types of art therapy interventions, which I have carried out in different institutions: 1) A “non-directive” open studio; 2) A “structured” art therapy group 3) Short-term “Individual art therapy”. I intend to show how these interventions, which sound very different, share the essence of the “one” art therapy method, using images and communication at different levels, in the art therapy setting.

Introduction.

The need to clarify the art therapy method is growing in urgency, now that all disciplines allied to medicine are expected to demonstrate evidence-based effectiveness. Art therapists are often part of multi-disciplinary teams, where there might be an expectation for the art therapist to clearly describe their method, in order to avoid duplications of both clinical approach and service. My view is that art therapists also need to distinguish between the art therapy method, which is one, and the multiplicity of art therapy interventions, which may be discussed and negotiated within the interdisciplinary team, according to patients' needs. In my opinion, art therapists should avoid the identification of the art therapy method with one specific art therapy intervention. Case and Dalley (1992) have offered a very clear and useful definition of the art therapy method, based on two factors: 1) the image making process, 2) the use of the image in the art therapy setting (p.53). The interaction between these two axes – which may be illustrated by a grid (see Fig.1) - gives rise to different art therapy interventions. Following this definition of the art therapy method, any art therapy intervention may be described according to *how the image-making process is facilitated* (which is the first axis), and according to *what type of communication is established* in the art therapy setting (which is the second axis).

In this paper I intend to describe three different art therapy interventions, which I offered at different times in my professional life: 1) The Drop-In Open Studio (London, Tooting Bec Psychiatric Hospital, 1987-90, with psychiatric patients); 2) The Creative Journey: A Short Term Structured Art Therapy Group (New York, Memorial Sloan-Kettering Cancer Center, 1995-2005, with cancer patients); 3) Individual Art Therapy (St Thomas' Hospital, 1990-1995, with patients diagnosed as "borderline"). I will analyze each art therapy intervention according to the two variables mentioned above, describing, in each art therapy setting: a) in which way the image-making process was facilitated; b) in which way the images were used and what kind of communication was established in the setting.

Fig.1: THE ART THERAPY GRID

The image-making process	The use of the image: types of communication		
	Intrapsychic	Symbolic/interactive	Inter-personal
From art materials	A1	A2	A3
From external images	B1	B2	B3
From inner images	C1	C2	C3

Throughout this paper I use the term ‘image making’ to represent all forms of art making that might occur during the course of art therapy. The grid has been inspired by Bion (1963), who suggested that all events during a psychoanalytic session may be described according to two elements: 1) *the type of thought* (vertical axis), and *the way the thought was used in the session* (horizontal axis).

(1) The Art Therapy Open Studio

The pioneers, and the emphasis on intra-psychic communication with patients suffering from psychosis.

Edward Adamson, who is recognized as one of the main art therapy pioneers in the UK, described his style of offering a psychological refuge to the psychiatric patients at Netherne Hospital, in his book *Art as Healing* (1984). Three words were sacred to him: “silence”, “safety”, and “concentration”. Each patient had his own easel and art materials, and Adamson tried as much as possible to facilitate what he called the intimate “face-to-face conversation” between the patients and their art work. He was not encouraging the interaction among patients, and tried to be least intrusive, silently protecting the space, trusting each patient’s creative potential, and not making comments nor interpretations on their art-work.

When I got a job at Tooting Bec Hospital in 1987, I learned that the Head of the Art Therapy Department, Helmut Muller, was a good friend and admirer of Edward Adamson. Like Adamson, Helmut wanted to offer a psychological refuge to the patients, who were referred by their psychiatrist, and could come from their wards every day, Monday to Friday from 9am to 5pm. They could drop-in for a few hours or stay for the whole day. Like Adamson, Helmut also wanted to facilitate the patients’ capacity for concentration, their pride in being creative, and their wish to give visual expression to their state of mind.

The image making process.

Helmut was always present, but often making pottery on his own on a separate table, and keeping a “watchful, not watching” position. I realized that each patient slowly developed a personal way of producing images. Some of them started from a casual, or playful use of art materials; others focused on outside images (like drawing an object from the room, or reproducing a painting from an art book); other patients intentionally

made images to express their state of mind. Learning about this tripartite way of producing spontaneous imagery was going to be very useful for me in the future, when I started to facilitate image making in different art therapy groups (see The Creative Journey, below).

The use of the images.

There was an important difference between Adamson and Helmut's Open Studio. Helmut had added an interactive dimension in the art therapy setting. First of all, the patients' images were placed on a huge board, and there they stayed, sometimes for days or for weeks, facilitating, on one level, distancing, mirroring and self-recognition and, on another level, respect for the images made by the other fellow patients. Also, patients used to socialize in a separate coffee room and here Helmut would often engage them in conversations about art and artists, encouraging them feel part of the dignified art world. Nevertheless, the intrapsychic dimension remained a priority, with its silent process of image making, and its silent distancing and mirroring. Helmut never allowed me to do any "group therapy" or "individual therapy", which he considered in contrast with the Open Studio approach. Being at the beginning of my professional life, I had only to learn from his experience, and what I learned became precious for my future. I started to provide groups and individual sessions in Day Hospitals and in other settings, but I never forgot the philosophy of the Open Studio, which can be useful for any populations, and can be included as a special intervention in any therapy program.

(2) A Short-Term Structured Art Therapy Group

The Creative Journey with oncology patients: the emphasis on symbolic-interactive communication.

The Creative Journey has been developed at Memorial Sloan-Kettering Cancer Center, New York, as part of the Art Therapy Service, which I led for ten years (1995-2005). The Creative Journey is a time-limited intervention: it consists of a series of ten weekly workshops, each lasting one hour and a half, for small groups of patients who have completed treatment. The explicit aim of this intervention was the development of personal imagination and creativity. The deeper aim was to help these patients, who had been traumatized by the illness and by the treatment, to reach their personal source of inner strength. All participants were seen individually at the end of the ten weeks for a follow-up, and were also given an anonymous questionnaire to mail back. Most participants wrote that the art therapy experience helped them to regain self-confidence and self-identity and to strengthen their way of coping, after the trauma of cancer diagnosis and treatment.

The image making process.

Each workshop started with a guided concentration, to help patients to establish a feeling of trust: trust towards the group, towards the space for image making, and towards the non-judging part of themselves.

The art therapist then explained the specific art therapy technique, which will be used on that day, to facilitate image making and the emerging of personal imagery. The ten techniques of the Creative Journey are based either on starting from the use of art materials, or from looking at external images, or from inner images. Each time, the core of the art therapy experience is the possibility to creatively develop or transform the first image (generally through the use of visual and/or verbal free association), into a more personal and meaningful image. We defined this process as the *“two-steps image”*.

Here is one example of the image-making process: the suggested technique on that day was to “play with tempera”, selecting three colours, and placing three blobs of tempera on a white page, then folding the paper, and reopening it again. Margaret selected green, yellow and blue. After folding the paper, and using free association, Margaret

saw “*a magician on a green field, gathering yellow energy, from the blue sky*” and she painted this image on a separate paper, as a second step.

The use of the images.

The style of the Creative Journey was based on the needs expressed by the participants: most participants had said they did not wish to talk explicitly about their illness (as opposed to most support groups run by the social workers in the hospital). The Creative Journey provided a silent environment and the development of symbolic/metaphoric imagery. In the second part of the sessions, the patients placed their images on the board, in order to distance from them, to allow self-recognition and self-reflection, and to develop respect for the images made by the other patients, even without knowing their meanings. A rule of the Creative Journey was to emphasize this “silent time”, while verbal sharing and getting a verbal feedback from the group was left optional, and only at the explicit request of each patient.

Following on the clinical example (above): Margaret told the group that in the second part of the image-making, while she was painting the new image of “*the magician on the green field gathering energy from the blue sky*”, she felt she got in touch with some inner resources, that she had almost forgotten about. Margaret did not add other personal details and did not ask for a feedback, but she took a photo of her painting, and said she was going to frame it and place it in her bedroom, and look at it every morning. Other patients behaved differently: some wanted a feedback from the group and did not talk about themselves at all; others wanted a feedback first, then moved into a deep explanation of the connection between the image and their life history. The social relationship among the patients was not encouraged, in order to keep the symbolic interaction more intense and meaningful.

(3) Individual Art Therapy

Borderline Patients.

When I was working at St Thomas' Hospital (1990-1994), I was part of the Psychotherapy Umbrella, which was led by Dr. Anthony Ryle, within West Lambeth Health Authority. Dr. Ryle had developed a special program for short-term cognitive-analytic therapy with borderline patients, but as he had a very eclectic mind he also trusted art therapy, and I grew professionally under his supervision. We discussed the techniques to *facilitate image making* during the individual sessions, and we discussed the techniques to *work with the images*, after they had been done (distancing, developing free association, modifying or transforming the image, creating alternative images).

The Image-making process.

The individual art therapy setting consisted of a small table, basic art materials (white and coloured paper, felt pens, pastels, tempera and collage materials like illustrated journals, scissors and glue), a sink in the room or near the room, and enough space on the wall to place the images and therefore to offer space and time to “work” on them.

The image making process was different for each patient. Some patients would start the session making an image, other patients wanted to talk first, and in these cases, usually the image was connected to the content of the verbal communication. Usually, a circular process would start, moving from an image to verbal conversation and from the verbal conversation to another image, and so on. The example I offer is an image made by Ann: a 22 year old girl who had been referred to me by her psychiatrist: she was suicidal, with compulsive eating and self-damaging behaviour. She described to me her habit of cutting the skin on her leg using tweezers. I suggested she would make an image of one of these events, and she did. In the drawing, the leg is on the left side of the page, and on the right side one can see a hand, holding the tweezers. While she

was working on the image, she pointed out that making this drawing felt very strange for her, because usually during that behaviour she would fall into a kind of sleeping/unconscious state of mind, while now – doing the drawing - she was perfectly conscious. In this case the mentalization process that is typical of the second stage (the use of the image), had already started in the first stage of image making.

The use of the image.

We placed the drawing on the wall, so that Ann could look at it for a while, and we could start to do “image-work”. I asked Ann whether it was okay for her to imagine *a dialogue between the leg and the hand* and she did. This is a technique that usually helps patients to connect behaviour and affect (some art therapists call this a Gestalt technique). Ann decided to write down the dialogue, and later she read it aloud to me. According Ann, the leg told the hand that “*she should stop doing that*”, as she was being “*intrusive and damaging*”. *The hand replied that she did not want to hurt the leg, but she liked the contact with the leg.* I asked Ann to write down again these two words “intrusive” and “damaging”, and to think about them. Then, after a long silence, Ann revealed to me that her father had been “intrusive and damaging” with her for many years. She had not told this to anybody, not even to her psychiatrist. I encouraged her to talk to her psychiatrist. We started a very fruitful cooperation, between Ann, her psychiatrist and myself. This led to Ann leaving home, renting a room by herself, and moving towards her recovery. The communication established in our individual art therapy sessions had been along the communication continuum: (a) intrapsychic, when she was very focused into her image making; (b) symbolic-interactive, when she made metaphoric images and talked about the images, remaining on the symbolic level; (c) interpersonal, when she discussed the practical difficulties of moving out and settling on her own, and her need of having extra sessions during that time.

In individual art therapy, the “image-work” may also be different for each patient, using visual and verbal communication and the interaction between the two, to respond to different needs (i.e. relaxation, catharsis, creativity, mentalization and insight).

Conclusion

Art therapists need to be professionally dynamic and creative, trusting the specificity of the art therapy method, but also articulating the type of image making process and the type of communication they wish to activate in the art therapy setting.

The image making process may be articulated in many ways. In this paper I have focused on three ways patients may use to reach personally meaningful images: (1) starting from a free use of art materials; (2) looking at external images – to copy them or to change them or to feel inspired by them; (3) expressing their inner world of feelings and thoughts (either directly or symbolically). In some interventions, like in a drop-in open studio, the patients start this process spontaneously; in other interventions – like in structured art therapy groups - the art therapist may facilitate the process (suggesting the use of certain art materials, or themes); and in other interventions – like in individual art therapy - it often precedes or follows a verbal interaction – with a circular process - between the patient and the art therapist.

The communication in the art therapy setting may be articulated according to a continuum, which moves from the intra-psychic dimension, based on safety and silence (typical of the Open Studio); to a symbolic-interactive dimension, where the triangular relationship is emphasized, and the art therapist and the patients talk to each other not directly but mainly through the images (as I have described in the Creative Journey); to a most flexible approach, which may include an emphasis on the interpersonal relationship (as it usually happens in Individual Art Therapy).

The interaction between these two basic elements (the image and the communication) is what makes the art therapy method particularly rich and fascinating. Art therapists are aware that some clients need to play with art materials, and others need to express their fears through symbolic images. Art therapists also know that the way the communication develops during the session may transform the playful use of art material into a deep emotional disclosure; and they know that fears may be healed through a symbolic and playful use of the images. Nevertheless, the clinical effectiveness of art therapy is still largely unproven. A clear definition of the art therapy

method and of the specific intervention used with the patients may facilitate interdisciplinary understanding and evidence-based research.

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